Guidelines for Medical Conditions and Medication-related Patient Alerts

This guideline supports the application of MP 0053/17 *Patient Alert Policy.*

Information in this section is provided as a recommended example of how the process may function within a hospital site. Sites may vary processes to meet individual circumstances.

It is up to the individual health service provider to assign authorisation to the appropriate position/s to enter the alerts onto the PAS.

Positions responsible for entering alerts must have undertaken education and training on patient alerts and use of the PAS.

1. Identification of alert and completion of paper-based patient alert notification form (e.g., MR ALERT 2 Form), or electronic equivalent

- During the patient's admission it is the responsibility of the treating clinician to raise a diagnosis which has the potential to be of critical importance to patients' management during their episode of care in accordance with specified medical, anaesthetic or medication-related alerts and specific detailing as per the paper-based patient alert notification or electronic equivalent, or in the appropriate place within the DMR.
- During the patient's admission it is the responsibility of the treating clinician or pharmacist to raise severe adverse drug reactions in accordance with specified clinical guidelines and specific detailing as per the patient alert notification form or electronic equivalent. This form must be forwarded to medical records (Health Information Manager Services) or clinical coding (depending on local health service provider processes) to enter onto the PAS. The form is then to be filed at the front of the medical record.
- Health Information Manager Services staff are required to identify records with new patient alert notification forms or electronic equivalents, for medical, anaesthetic or drug alerts. Clinical coding staff should initiate a patient alert if alerts are identified during coding.

2. Authorisation process

- The Patient/Clinical Alert Committee (CAC) or equivalent authority (depending on size of institution - ideally a medical officer or clinical pharmacist for medication-related patient alerts) is responsible for governance of patient alerts for each site will review all

medical alerts and drug alert queries in a timely manner, with the exclusion of anaesthetic and other specified alerts.

- Some patient alerts can be raised/entered by clinical coding staff without co-authorisation (including, but not exclusive to organ transplant, heart valve replacements, pacemaker or other implanted devices when inserted during the admission being coded, asplenia, and Advance Health Directives). Alerts that meet this criterion should be decided by the governing body within the hospital.

3. Data entry and file form in medical record

- Once the patient alert has been approved by the CAC or equivalent authority, the alert must be entered into the PAS. This must be undertaken by persons authorised to enter patient data onto the PAS. If no authorised person is available in the clinical area, the patient alert notification form or electronic equivalent, should be forwarded with the medical record (if requested) to the Medical Records Department to be entered onto the system.

4. If the proposed patient alert is NOT approved for entry onto PAS

- If on review the alert is not deemed to be a patient alert (i.e., it is not a serious/life threatening issue) but is still required to be captured in the patient's medical record (such as mild to moderate side effects to a drug), the position (gatekeeper or delegated committee representative) responsible for approval of alerts should ensure the alert (medical, anaesthetic or drug alert information) is documented on the inside cover of the health record, on the patient alert notification form or electronic equivalent, or in the digital medical record in situations where the patient alert is not already documented.
- The patient alert notification forms should be cancelled and the reason why the alert is not approved should be documented. The MR ALERT 2 Form should still be filed as a record of the proposed patient alert with reason why it was not approved.

5. Inactivation of alerts in the PAS

- If an alert is no longer relevant or is entered in error, it will need to be inactivated in the PAS to reduce the risk to the patient and a comment provided to clarify reason for inactivation.
- When the alert codes are being reviewed and need to be updated (new ones added or obsolete ones inactivated) then a change request should be raised by the CAC or equivalent authority, to update the PAS, and the relevant communications sent to stakeholders regarding the change.

6. Recommended process for alert queries within hospitals

- The CAC or equivalent authority responsible for governance of patient alerts for each site will review all medical alerts and medication alert queries, with the exclusion of anaesthetic and other specified alerts.

- The Chair, Clinical Alert Committee or equivalent authority will:
  - Review medical records/patient alert notification form/s flagged as containing new alerts.
  - Approve/not approve patient alert notification forms and adjust wording as needed.
  - Process the alert accordingly for updating in the PAS.

Where a patient alert for a patient does not fit within one of the specified categories the Medical Other or Medication/Drug Other category may be used.

These 'Other' categories must only be used for patient alerts that are potentially life-threatening conditions that are crucial for treating physicians to be alerted to immediately on patient presentation to hospital/episode of care. The use of these codes will be reviewed periodically by the Patient Alert Business Advisory Group to determine if new codes are required.

Patients must be informed about any new identified risks and given written instruction when they are discharged, about who they should inform about their identified risks i.e., GPs, community pharmacists or any other health professionals involved in their future care. Patients should be encouraged to update or create a 'My Health Record' with information about any identified risks.

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